PA Request Criteria

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CAREFIRST
Testosterone Products GR

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Testosterone Products GR.

Patient Name: _____ **Date:** 3/31/2025
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
_____ **NPI#:** **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**
_
Drug Name (specify drug) _____
Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1.	Is the requested drug being prescribed for age-related hypogonadism (also referred to as late-onset hypogonadism)?	**Y** ☐	**N** ☐
2.	Is the requested drug being prescribed for primary or hypogonadotropic hypogonadism?	**Y** ☐	**N** ☐
3.	Is this request for continuation of therapy?	**Y** ☐	**N** ☐
4.	Before the patient started testosterone therapy, did the patient have a confirmed low morning testosterone level according to current practice guidelines or your standard lab reference values?	**Y** ☐	**N** ☐
5.	Does the patient have at least two confirmed low morning testosterone levels according to current practice guidelines or your standard lab reference values, before the start of testosterone therapy?	**Y** ☐	**N** ☐
6.	Is the requested drug being prescribed for gender dysphoria in a patient who is able to make an informed decision to engage in hormone therapy?	**Y** ☐	**N** ☐
7.	Are the patient's comorbid conditions reasonably controlled?	**Y** ☐	**N** ☐
8.	Has the patient been educated on ANY contraindications AND side effects to therapy?	**Y** ☐	**N** ☐
9.	Is the patient less than 18 years of age?	**Y** ☐	**N** ☐
10.	Is the requested drug being prescribed by, or in consultation with, a provider specialized in the care of transgender youth (e.g., pediatric endocrinologist, family or internal medicine physician, obstetrician-gynecologist), that has collaborated care with a mental health provider?	**Y** ☐	**N** ☐
11.	Has the patient reached, or previously reached, Tanner stage 2 of puberty or greater?	**Y** ☐	**N** ☐
12.	Is the patient new to testosterone therapy?	**Y** ☐	**N** ☐
13.	Has the patient been informed of fertility preservation options?	**Y** ☐	**N** ☐
14.	Is this request for testosterone propionate implant pellets (Testopel)?	**Y** ☐	**N** ☐

15. Is this request for intramuscular testosterone enanthate injection (generic Delatestryl)? **Y** ☐ **N** ☐

16. Is the requested drug being prescribed for inoperable metastatic breast cancer in a patient who is 1 to 5 years postmenopausal and had an incomplete response to other therapy for metastatic breast cancer? **Y** ☐ **N** ☐

17. Is the requested drug being prescribed for a pre-menopausal patient with breast cancer who has benefited from oophorectomy and is considered to have a hormone-responsive tumor? **Y** ☐ **N** ☐

18. Is the requested drug being prescribed for delayed puberty? **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date